



### Out-of-State Application for Licensure as an EMT-Basic, EMT-Intermediate, or EMT-Paramedic

I hereby request licensure as an ☐ EMT-Basic ☐ EMT-Intermediate ☐ EMT-Paramedic and submit the following application and credentials:

Full Name:		
Last	First	Middle
Mailing Address:		
City	State	Zip
(Area Code) Resident Phone Number	(Area Code) Business Phone Number	Social Security Number
National Registry Certification Number	Date Issued MM/DD/YYYY	Expiration Date MM/DD/YYYY
Do you hold any other license(s) or certificate(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No      If Yes, complete the following:		
Kind of Certificate/License and State of Issuance	Certificate/License Number	Date Issued

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and legal disposition of the matter.

	YES	NO
Have you ever been treated or hospitalized for mental illness, drug or alcohol abuse?		
Have you ever been convicted of violation of any National, Federal, State, or Local Statute?		
Have you ever been denied the privilege of taking an examination given by any state licensing board or been denied a certificate or license?		
Has any state licensing board revoked or suspended a certificate or license issued to you, or taken any other disciplinary action?		
Have you ever had any malpractice suits filed against you?		
Have you ever resigned from any employment after a complaint or peer review action has been initiated against you?		
Have you ever voluntarily surrendered a certificate or license for any reason?		
To your knowledge, are you the subject of any investigation by an licensing board as of the date of this application?		

A copy of the following required documents must be submitted at the time of this application:

- Copy of current NREMT-Basic, NREMT-Intermediate, or NREMT-Paramedic wallet card
- Documentation attesting to current CPR credentials
- Documentation attesting to current ACLS credentials if applying for EMT-Paramedic
- Copy of high school diploma or equivalent
- Proof of completion of a state approved course
- Documentation verifying 18 years of age
- Current national criminal record history report generated no earlier than twelve (12) months prior to submitting an application for licensure
- Passed Advanced Tactical Practitioner written exam and hold current credentials. ( ATP applicants only)
- Cashiers check or money order, drawn on a United States bank, made payable to the "Georgia Department of Community Health" for the appropriate level of licensure. EMT-Basic \$25.00, EMT-Intermediate \$50.00, or EMT-Paramedic \$75.00



## AFFIDAVIT OF APPLICANT

I acknowledge and state that I have read and answered all questions in compliance with this application. I acknowledge that it is my responsibility to read and become familiar with the Georgia Department of Community Health Rules and Regulations for Emergency Medical Services 290-5-30.

I further state that by filing this application for a license in the State of Georgia, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for practice as an EMS provider. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of the report or know its contents and I further understand that the content of the investigative report will be privileged, unless determined otherwise by the Board or Court Order.

I hereby release, discharge, and exonerate the Georgia Department of Community Health, its agents, representatives, and any person so furnishing information, from any and all liability of every nature and kind arise out of the furnishing or inspection of such documents, records or other information or the investigation made by the Georgia Department of Community Health. I authorize the Georgia Department of Community Health to release information, material, documents, orders of the like relating to me or to this application to any other agency of the State of Georgia, the licensing agency of any other State or Territory of the United States or Providence of Canada, a law enforcement agency, a hospital, or other agencies determined by the Board.

This is to certify that the foregoing information is true and correct to the best of my knowledge. I understand that any person who shall give false or forged evidence of any kind to the Board may be prosecuted to the fullest extent allowed by law.

\_\_\_\_\_  
Signature of Applicant Date

City \_\_\_\_\_ State \_\_\_\_\_

\_\_\_\_\_  
Name of Applicant

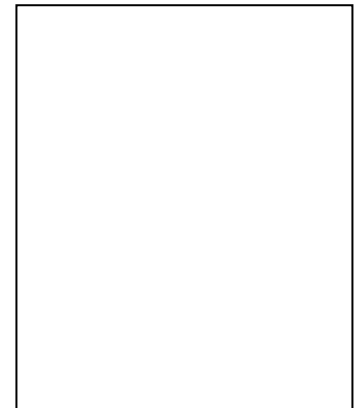
Being duly sworn, says that he/she is the person who executed this application for licensure as an EMS provider in the State of Georgia; and that all the statements herein contained are true in every respect and that the attached photo is a true photo of applicant.

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public

My Commission Expires \_\_\_\_\_

( SEAL)



Notary: DO NOT notarize this section unless a passport photograph is attached.



GEORGIA DEPARTMENT OF  
COMMUNITY HEALTH  
Division of Emergency Preparedness & Response  
Office of Emergency Medical Services & Trauma

This form is used to verify the good standing of EMT or paramedic license or certification applicants who are licensed or certified by another state.

**PART I: Completed by Applicant**

Name: \_\_\_\_\_ SS# \_\_\_\_\_

Current Address: \_\_\_\_\_

I am requesting Georgia license based on the following current license(s) or certification(s):

\_\_\_\_ in the state of \_\_\_\_\_ AND by the National Registry of EMTs

Current certification(s) or license(s) in another state or issued by the National Registry of EMTs"

EMT-Basic Certificate # \_\_\_\_\_ Expiration Date \_\_\_\_\_  
EMT-Intermediate Certificate # \_\_\_\_\_ Expiration Date \_\_\_\_\_  
EMT-Paramedic Certificate # \_\_\_\_\_ Expiration Date \_\_\_\_\_  
Other (specify) \_\_\_\_\_ Certificate # \_\_\_\_\_ Expiration Date \_\_\_\_\_

**PART II: Completed by the State Certifying Agency**

Please assist by verifying that this individual is currently certified and in good standing according to your certification policies.

- A. Is the above-referenced cited certificates(s) or license(s) deemed current and valid according to your policy? ☐ Yes ☐ No
- B. Has the above certification(s) or license(s) ever been revoked or suspended? ☐ Yes ☐ No  
If yes, please explain \_\_\_\_\_
- C. Has the above listed individual ever been convicted of a felony? ☐ Yes ☐ No  
If yes, what was the offense? \_\_\_\_\_  
Date of conviction \_\_\_\_\_ Place of conviction \_\_\_\_\_
- D. Do you know of any reason licensure in Georgia should be denied? ☐ Yes ☐ No  
If yes, why \_\_\_\_\_

Verifying Person's Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Agency Name: \_\_\_\_\_ State: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_

**MAILING INFORMATION:**

Your application cannot be processed without a Statement of Good Standing. Include this document with your completed application packet and mail to:

Office of Emergency Medical Services/Trauma  
ATTENTION: Personnel Licensing  
2600 Skyland Drive, Lower Level  
Atlanta, GA 30319